THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-1455.M5

MDR Tracking Number: M5-04-0745-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 11-7-03.

Dates of service prior to 11-07-02 were submitted untimely per above referenced rule and will not be considered further in this decision.

The IRO reviewed office visits, electric stimulation, physical medicine procedure, myofascial release, joint mobilization, mechanical traction rendered from 11-25-02 through 2-27-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On February 10, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

No EOB: Neither party in the dispute submitted EOBs for some of the disputed services identified above. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per *Medical Fee Guideline.*

House Bill 2600 abolished the treatment guidelines effective January 1, 2002; therefore, the insurance carrier incorrectly denied disputed service with EOB denial code "T." Disputed services denied with EOB denial code "T" will be reviewed in accordance with the Commission's *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12-4-02 12-6-02 12-11-02	99213MP 97032 97250	$48.00 $23.00 $45.00	$48.00 $22.00 $43.00	F	$48.00 $22.00 $43.00	EOB	EOB indicates these services were paid in accordance with MFG.
12-4-02 12-6-02 12-11-02	97139SS	$27.00	$20.25	M	$25.00	Section 413.011(b) Rule 133.307(g)(3)	The requestor did not submit documentation challenging insurance carrier's payment as not complying with statute, no reimbursement is recommended.
12-4-02 12-6-02 12-11-02	97265	$45.00	$0.00	T	$43.00	HB-2600	MAR payment of 3 dates X $43.00 = $129.00
11-15-02 11-18-02 11-20-02 11-22-02 12-27-02 12-30-02 1-7-03 1-9-03 2-19-03 2-20-03 2-24-03 2-27-03	99213MP	$48.00	$0.00	No EOB	$48.00	CPT Code Descriptor	MAR payment of 12 dates X $48.00 = $576.00
11-15-02 11-18-02 11-20-02 11-22-02 12-27-02 1-7-03 1-9-03 2-19-03 2-20-03 2-24-03 2-27-03	97032	$23.00	$0.00	No EOB	$22.00	CPT Code Descriptor	MAR payment of 11 dates X $22.00 = $242.00
11-15-02 11-18-02 11-20-02 11-22-02 12-23-02 12-27-02 1-7-03 1-9-03 1-13-03 1-27-03 1-28-03 1-30-03 2-19-03 2-20-03 2-24-03 2-27-03	97139SS	$27.00	$0.00	No EOB	DOP	CPT Code Descriptor	Carrier did not dispute amount billed was not fair and reasonable; therefore, payment of 16 dates X $25.00 = $400.00.

11-15-02 11-18-02 11-20-02 11-22-02 12-27-02 1-7-03 1-9-03 2-19-03 2-20-03 2-24-03 2-27-03	97250	$45.00	$0.00	No EOB	$43.00	CPT Code Descriptor	MAR payment of 11 dates X $43.00 = $473.00
11-15-02 11-18-02 11-20-02 11-22-02 12-27-02 1-7-03 1-9-03 2-19-03 2-20-03 2-24-03 2-27-03	97265	$45.00	$0.00	No EOB	$43.00	CPT Code Descriptor	MAR payment of 11 dates X $43.00 = $473.00
1-27-03 1-28-03 1-30-03	99213MP	$48.00	$0.00	N	$48.00	CPT Code Descriptor	Documentation supports billed service, reimbursement of 3 X $48.00 = $144.00.
1-27-03 1-28-03 1-30-03	97032	$23.00	$0.00	N	$22.00	CPT Code Descriptor	Documentation supports billed service, reimbursement of 3 X $22.00 = $66.00.
1-27-03 1-28-03 1-30-03	97250	$45.00	$0.00	N	$43.00	CPT Code Descriptor	Documentation supports billed service, reimbursement of 3 X $43.00 = $129.00.
1-27-03 1-28-03 1-30-03	97265	$45.00	$0.00	N	$43.00	CPT Code Descriptor	Documentation supports billed service, reimbursement of 3 X $43.00 = $129.00.
TOTAL							The requestor is entitled to reimbursement of **$2761.00.**

IV. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for CPT code(s) 99213MP, 97032, 97139SS, 97265, 97250 the amount of **$ 2761.00.** Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **$2761.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 10th day of September 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

Roy Lewis
Medical Dispute Resolution Supervisor
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION amended

February 8, 2004

Re: IRO Case # M5-04-0745
IRO Certificate # 4599

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient injured his neck, right shoulder and lower back in ___ when a 30-pound box that he was throwing on a truck fell back and he stopped it from falling further. The patient has had numerous medical evaluations, and was treated with medications, physical therapy, chiropractic treatment, lumbar ESIs, and work conditioning.

Requested Service(s)
Ovs with manipulation, elec stim, myofascial release, jnt mobil, mech traction, therapeutic procedure 11/25/02-2/27/03.

Decision
I agree with the carrier's decision to deny the requested services.

Rationale

The patient received extensive conservative treatment prior to the dates in dispute with little documented support that treatment was effective in relieving symptoms or improving function. The records provided for this review are repetitive on a daily basis, and lack objective measurements for loss of motion, orthopedic tests and loss of strength and sensation that would be necessary to support continued treatment. The doctor's treatment plan never changed even though the patient showed minimal, if any, response to treatment. The patient was being treated for a diagnosed hip and thoracic strain while all along he was complaining of neck and low back pain, yet there were no objective findings provided for this review to support treatment of these areas. The diagnosis never changed. During the first nine months of treatment the patient received some 70 treatment sessions. This was excessive, and inappropriate treatment based on the documentation presented. Appropriate care would have included 24 treatment sessions over a 10-12 week period. Further treatment beyond this time period should have been supported by documentation that treatment was beneficial or that exacerbations or aggravations had occurred that necessitated more time. No such documentation was presented for this review.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.